

MEDICAL HISTORY

Name: _____

Reason for today's visit: _____

List all medication allergies: _____

List all medications you are taking: _____

Do you have a pacemaker? Yes ___ No ___ Do you take Aspirin or Blood thinners? Yes ___ No ___
Do you have a defibrillator? Yes ___ No ___

Medical History

Have you ever had a disease or conditions of:

Please check yes or no

	YES	NO		YES	NO
Diabetes	_____	_____	Emphysema	_____	_____
Thyroid	_____	_____	Asthma	_____	_____
Kidney	_____	_____	Chronic Cough	_____	_____
Bladder	_____	_____	Morning Cough	_____	_____
Stomach	_____	_____	High Blood Pressure	_____	_____
Bowel	_____	_____	Chest Pain	_____	_____
Heart Attack	_____	_____	Glaucoma	_____	_____
Arthritis	_____	_____	Irregular Heart Beat	_____	_____
Epilepsy	_____	_____	Phlebitis	_____	_____
Seizures / Fainting	_____	_____	HX Melanoma	_____	_____

Have you ever been exposed to **HIV (AIDS)**?

Yes ___ No ___

Do you have **Hepatitis**?

Yes ___ No ___

If yes, Type ___ Date of diagnosis _____

Do you drink alcohol daily?

Yes ___ No ___

Have you ever had dental anesthesia? (NOVACAINE)

Yes ___ No ___

SKIN

Have you ever had skin cancer?

Yes ___ No ___

Do you have a history of any specific skin diseases?

Yes ___ No ___

Anyone in your **immediate** family ever had skin cancer

Yes ___ No ___

List any other conditions we should know about: _____

List any surgical procedures you have had in the last 6 months: _____

Do you smoke? Yes ___ No ___

(Women) Are you pregnant? Yes ___ No ___

Patient or Responsible Party Signature

Date